ASSOCIATION FOR HEALTHCARE FOODSERVICE

FOOD & NUTRITION SERVICE
BEST PRACTICES IN FINANCIAL MANAGEMENT

UPDATED: 2021

A GUIDE FOR FNS LEADERS
TO IMPLEMENT, MAINTAIN AND ENHANCE
EFFECTIVE FINANCIAL MANAGEMENT AT DEPARTMENT LEVEL

A publication of the AHF Self-Operated Project Team

AHF SELF-OPERATED PROJECT TEAM

PURPOSE

This guide is intended to provide leaders in Food and Nutrition Services (FNS) a current understanding of practices in financial management that can assist in approving the overall performance of their departments. We hope to provide seasoned leaders, as well as those who are still developing FNS competencies, with a firm foundation in Healthcare financial accounting. Many will find the information instructive as an update, and useful in increasing their effectiveness in departmental management. We also hope that this guide helps talented managers acquire the skills to manage financially sound operations and add value to the institutions they serve.

CHAPTER 1
INTRODUCTION

OVERVIEW

The healthcare industry faces the challenge to provide higher quality care to an increasing volume of citizens while operating in an uncertain reimbursement climate. Leaders scrutinize every dollar spent to assure delivery of full value and are constantly seeking increased value over time. As a result, effective financial management is essential for the FNS operation to succeed. The Management Control Process begins with Financial Management and the protection of business assets.

When you are able to speak and understand financial terms exactly like your CFO (Chief Financial Officer) or Budget Director, you will be able to effectively communicate the current and expected states of your department and operation to the executive team. Accountants and Financial Professionals learn: Generally Accepted Accounting Practices (GAAP). Financial executives communicate using GAAP terminology. But do not fool yourself into thinking that what you learned about accounting in school holds true today. In 2009, the FASB (Financial Accounting Standards Board) partnered with the American Accounting Association (ASA) to create the FASB Accounting Standards Codification (ASC). This update is an important piece of education for any administrator who manages finances or budgets.

You need to be financially astute and demonstrate ongoing continuous improved operational performance. This increases the leader's perceived value to the organization. In the world of lean management, data gathering and analysis is key to identifying improvement opportunities and developing the plans needed to implement those strategies.

FNS leaders live in a competitive world. Internal competitors seek access to the same limited resources available, including labor budgets and capital improvements. External competitors strive to draw retail foodservice customers' offsite – or deliver within the walls. An additional threat is the possibility of outsourcing to food management contract companies. These contractors seek to expand and improve their profit margins by promising hospital executive's improved financial, operational expertise and performance. Beating the competition requires not only excellent performance, but also effective communication. Leaders need to make sure that their executives are aware of the department's performance and have a firm understanding of the associated costs the FNS department.

MANAGEMENT MODEL

The purpose of Food & Nutrition Services program is to deliver quality service to patients and other customers. This is done by improving the services provided, by replicating best practices, and generating overall cost reduction via: operational standardization, automation, and process improvement. The management model must be consistent with the healthcare system's Mission, Values and Vision, as well as support the system's strategic plan.

Therefore, your departmental Business Plan should include a budget, goals, objectives, and financial targets that support the initiatives noted above. Done properly, this type of financial management will demonstrate a clear difference between Self-Operated and Contract Managed foodservice operations. Closely sharing a culture allows Self-Op to speak to in terms of "Us", how "We" do things together. Otherwise, the Finance Department must refer to contractor's practices as how "they" function or operate.

1. Contracts with vendors are in place to protect assets and assure that the contractor adheres to all applicable laws and regulations. This helps to minimize risk to the client.
2. Financial reports are created, presented, and reviewed on a timely basis including: Balance Sheet, Prime Cost, Income Statement, Cost of Goods Sold, EBIDA (Earnings before Interest Depreciation and Amortization), and Net Profit or Loss.

Traditionally, decisions regarding the management of FNS rests with local leadership on a hospital-to- hospital basis. As a result, there has been significant variation in the management approach to FNS across the industry. More recently, we have seen the aggressive growth of healthcare systems, a severe reduction in freestanding; or unaffiliated hospitals, and additional decisions being made at system levels regarding anything impacting the system's financial performance. Therefore, this guide is intended to be instructive to those with or considering outsourcing of various services in order to fairly compare and evaluate the before and after of such changes. If these kinds of decision no longer rest with local leadership, it will help to understand system level decisions that are likely to be data-driven. Therefore, it becomes even more critical to understand financial performance.

Opportunities exist for self-operated foodservice leaders to take the initiative and demonstrate the value of collaboration. Networking with peers, sharing tools and strategies, and developing joint proposals for significant projects, will validate their value to the healthcare system. Effective use of resources can be demonstrated using AHF *Benchmarking Express™, the largest self-operated healthcare foodservice cost data base in the US*. Gaining Information from AHF list-serves and other association resources can also help operators to demonstrate leadership at key times.

SELF-OPERATED FOODSERVICE

LEADERSHIP

There is typically an assigned C-Suite Leader, often the Chief Operating Officer (COO) and a Department Director who have full responsibility for the food and nutrition service operation. If either of these individuals have limited experience in healthcare foodservice or lack an understanding of key performance (KPI) metrics, the operation will suffer. In some systems, there is a shared service or consolidated management model. In those cases, in addition to the hospital senior leadership and department director, there is leadership and support at the system and/or regional levels, providing professional expertise to address opportunities for improvement and savings. Where there is not a system approach, the communication and shared learning between the key leaders is critical to success and in acquiring the highest value.

SYSTEMS

In the past, smaller operations typically functioned with little or no automation, due to the initial cost of acquisition and the labor required to implement and maintain the software (app). Manual systems left room for human error, are also labor intensive and increased liability risk. Some healthcare systems are implementing FNS software systems on a system or regional basis. Sharing the expense and supporting the system across many facilities.

Integrated software systems can reduce labor costs, reduce food waste, improve staff efficiency, and most importantly reduce patient safety risk factors. The use of integrated foodservice software systems is a best practice for healthcare foodservice operations.

REDUNDANCY

When each facility repeats the same activity with limited opportunity for economies of scale or collaboration. Hours are spent in multiple locations on the same activities: purchasing/GPO compliance, product selection and utilization, and menu development and management. Again, healthcare systems are looking, particularly through supply chain leaders to assist with ways to support collaboration and standardization. Professional involvement and networking across sites can greatly enhance the reduction in overall system redundancy, while improving financial and operational performance.

OUTCOMES

Inconsistent performance on KPI's with varying levels of resources allocated, can result in broadly different costs across the system. Collaborating with peers, networking in the industry, and benchmarking with similar type and sized facilities, can show immediate results without the expense and inconvenience of outsourcing.

OUT-SOURCED MANAGEMENT

LEADERSHIP

The senior leader assigned by the hospital acts primarily as a liaison with responsibility to oversee the contract and outcomes. The outsourced department director, supported by a district manager and various support services, offers what appears to be greater acumen and efficacy. The support provided by the corporate structure reassures the local hospital executive that the operation is in expert hands – and is not dependent on his/her skills.

STAFFING

The outsourced provider employs the department management and/or the entire department staff. All related HR issues become the responsibility of the company for their employees. Frequently hourly rates and benefits are lower than paid directly by the hospital, offering short-term savings, at the expense of the department staff. This can cause public relations problems in organizations that promise a standard minimum wage to all employees, as well as feelings of inequity between departments. A separate HR application process, background checks and source for physical exams and lab tests are another example of outsourcing redundancy.

APPEALS VERSUS REALITY

Promise of Qualified Staff, Management Support & Systems

- This comes with less control of the operation and makes it more difficult to reconcile performance to expectations.
- Managers face mixed allegiance between the hospital where they work and the contractor that employs them. Contract managers must also maintain dual reporting and distinct accountability measures.

Expected/Guaranteed Results

- Contracts sold based upon service enhancements tend to lack incentives to reduce costs for the hospital. Guaranteed

OUT-SOURCED MANAGEMENT CONTINUED

results often have very minor penalties for missed performance.
- Non-aligned goals and conflicting priorities between the hospital and the outsourced vendor create challenges regarding how employees spend their time and allocate resources.
- Service level disparity results from differences between the priorities and expectations.

Purchasing Power

- In fact, healthcare group purchasing organizations (GPO) compete effectively when there is greater volume and managers honor the contracts via high levels of compliance. Modern GPO's enjoy the same discounts and purchasing power as contract companies.
- GPO's who work with contract management companies keep a certain percentage of the rebates offered, and incentives based on the amount of purchases the contractor makes. Example: A contractor gives the client 3% of the rebates back and keeps 10%. A self-operator maintains 100% of the rebate.

Innovation & Technology

- Although outsourced management vendors have robust data systems to analyze performance, the proprietary systems allow the company to maintain strict control of the data and access to the reports.
- This proprietary system quickly becomes a liability if the client ever wished to terminate the contract. The management company will exit with the system and leave a void in department technology including: Diet and Clinical with EMR interface, education and training records, proprietary teaching material, Purchasing, production, and Point of Sale (POS) software, and financial records.
- Technology implemented by the hospital matches the functionality and because the hospital owns and controls the data, the long-term impact on financial performance exceeds the outsourced system.
- Innovative programs customized to the defined needs of the organization result from talented department leaders, engaged in professional education, following industry trends, and focused on local culture.

Access to Capital

- Although outsourced vendors often advance capital for physical improvements, the repayment schedule extends throughout the life of the agreement in higher operational expense, often at non-competitive rates. If the client terminates the agreement for any reason, including non-performance, the remaining capital obligation becomes due.
- Outsourcing impacts multiple line items in the financial statement. Although leadership focuses on the purchased service costs, there are numerous other costs spread throughout the general ledger, often without the typical senior leadership oversight and approval, creating increased department expense that becomes difficult to identify. Costs transferred to other general ledger accounts and cost centers create additional challenge to identify the true cost of operation.
- Automatic escalation clauses with fees increasing annually are typical in management contracts. At a time when hospital reimbursement levels are declining, this annual growth rate can be daunting in a multi-year contract. The investment and cash outlay are programed to grow and may never allow for reduction.

"If you fail to plan, you are planning to fail."
Benjamin Franklin

CHAPTER 2
DEVELOPING THE PLAN: GOAL SETTING

Success requires planning and planning requires defining the current state. Using data, the FNS leader defines the current operational strengths and weaknesses to begin the planning process. Begin by defining the scope of the business unit.

BUSINESS UNIT SCOPE

Total Operating Expense (TOE)

- Total operating expense includes all the direct expense attributed to the operation of the FNS department. This includes all salaries, wages and direct benefits, supplies, purchased services and other direct expense.

Paid Revenue

- Revenue from all retail foodservice operations helps to define the scope of the operation. This includes cafeteria receipts (cash, credit/debit, payroll deduct), vending revenues or commissions, Coffee Shops, C-stores, gift shops, or other retail outlets managed by FNS, paid catering sales, other services sold, such as meals on wheels, or meals transferred to other operations, and actual revenue from clinical nutrition and/or medical nutrition therapy (MNT). (When including clinical revenues, work with finance to assure that the total reflects only actual net revenue versus gross charges.) Calculating the percent cash represents Total Managed Volume (TMV) and assists in showing the value of retail operations. This becomes not only a way to define the scope but a key metric for tracking effectiveness.

Total Managed Volume (TMV)

- Outsourced management vendors define the size of the operation by TMV, which is the sum of the total operating expense plus the revenue, based on the concept that an effective manager is controlling both revenue and expense. This provides a single number, which defines the unit's size, easily understood by all within the contract company. The incentives for the managers are to make this number higher, whether or not the client's goal is to reduce expenses. Self-operated puts greater weight on Meal counts (services provided) and achieving the lowest "cost per meal", as opposed to comparing business unit volumes.

Paid FTE

- Stating the labor complement as full-time equivalents (total annual hours divided by 2080), versus the number of colleagues or positions, defines the human assets in a comparable term to other business units.
- In a contract managed account, there is a guaranteed FTE rate in the contract. This is usually more than what is used including a higher percentage of benefit costs. The contractor keeps the difference as part of the field contribution (profit). ie, charging for 50 FTE's when they run 48, charging 38% benefit when the actual is 30%.

Number of Service Units

- Reflect the volume of units in the business, which may include multiple retail outlets, more than one hospital/facility, or other offsite retail or service locations.

METRICS AND PERFORMANCE MONITORING

FNS leaders establish key metrics for the operation in conjunction with finance and executive leadership. Metrics define the baseline and measure performance compared to the baseline, established targets and industry benchmarks.
(Refer to Glossary for definition of metrics listed)

KEY METRICS FOR FNS

- Financial Performance: Total Operating Expense per Adjusted Patient Day (net of cash)
- HR Performance: Colleague or Employee Engagement Score
- Quality Performance: Patient Satisfaction Rate
- **Additional Ratios and Utilization Rates**
  - Patient Meals per Patient Day or Adjusted Patient Days
  - Meals per labor hour or per productive labor hour
  - Floor Stock Cost per Patient Day
  - Paid Revenue as a % of Total Managed Volume
  - GPO Contract Utilization Rate
  - Inventory Turns (rate)
  - Span of Control Ratio: Colleagues per Leader
  - Productive Hours per 100 Meals
  - Position Vacancy Rate
  - Colleague (Employee) Turn-over Rate

ANNUAL BUSINESS GOALS

FNS leaders use data defining the current state, compared to industry benchmarks, and executive expectations to establish short term, intermediate, and long-term performance goals. Examples of goals may include:

- Reduce overall net cost per APD by xx% versus prior year via reducing food and supply expense, enhancing productivity, increasing revenue and reducing purchased service costs.
- Provide consistent enhanced service levels for all customer groups: patients, employees, physicians, and volunteers, as measured by patient satisfaction, physician satisfaction, employee engagement, and cafeteria

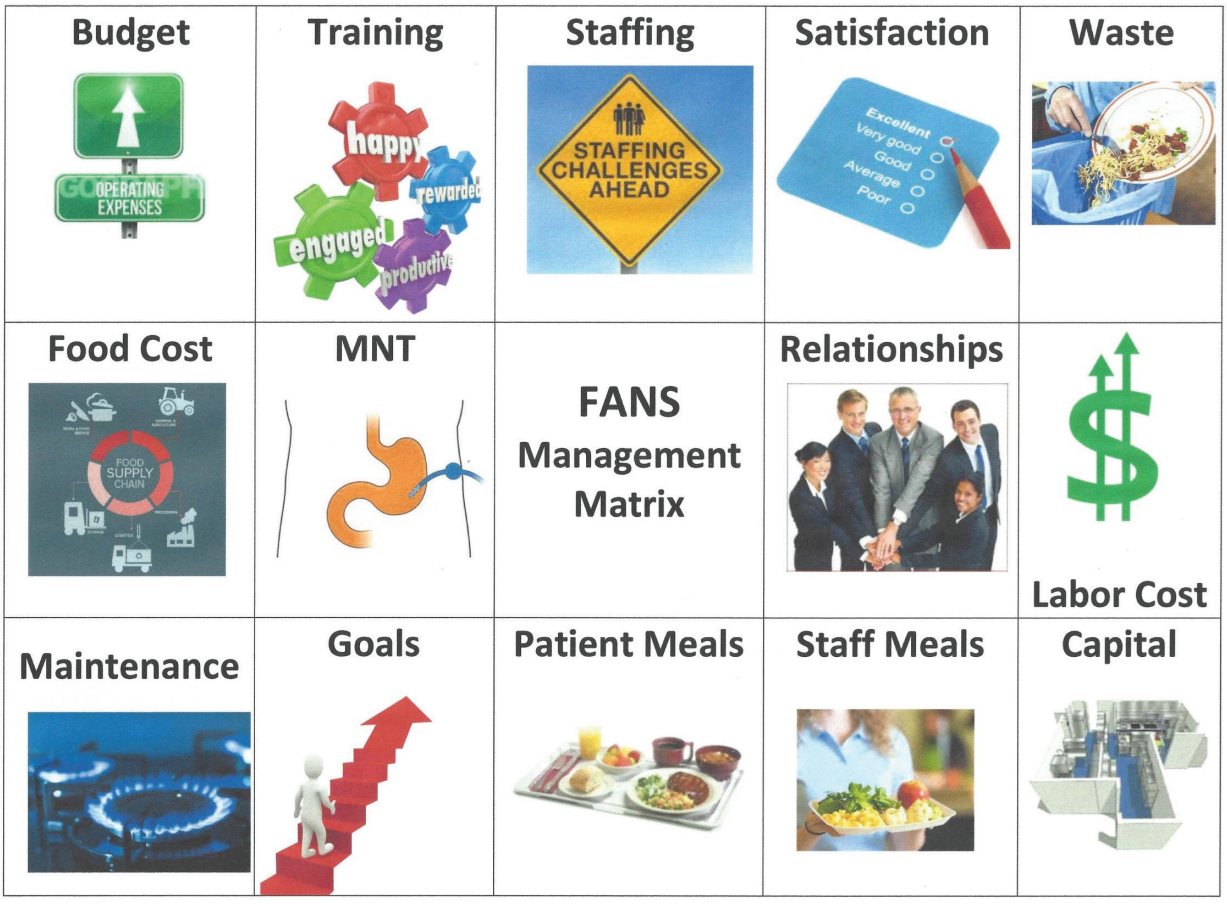


Figure #1 The FANS (Food and Nutrition Services) Management Matrix

participation.
- Reduce risk of patient safety lapse due to allergy or critical diet order errors.
- Enhance delivery of clinical services and clinical nutrition effectiveness.
- Increase revenue production in retail operations while improving margin management.
- Improve productivity by achieving at least 100% of targets for productive labor per unit of service.

DATA-DRIVEN PROCESS IMPROVEMENT

Audits validate the baseline and work teams develop strategies and initiatives to improve performance. Various Lean tools (see Glossary for reference) further measure and track performance improvement, allowing the teams to adjust the initiatives based on performance. For each initiative, begin by identifying both lagging and leading metrics, comparing long-term success, as well as predicting incremental improvements.

TOOLS AND TECHNIQUES FOR DATA GATHERING AND ANALYSIS

FNS departments (like every other department) run most effectively with a steady supply of data, and timely data analysis. The FNS director or designee should be reviewing statistics and specific data points daily. Other data points will need to be added or deleted as opportunities for improvement arise.

Suggested daily data monitors to consider (all data should be from the previous days service)

- **# Retail transactions** – Available via point of sale (POS) system
- **# Patient meals** – Available via patient services software
- **Productive labor hours** – Available via payroll or budget app
- **Non-Productive labor hours** – Available via payroll or budget system
- **Listing of callouts or call-offs** – Available via department daily log and entered into the payroll app
- **Equipment issues** – Available via department daily log or engineering log (service provider app)
- **Operational issues** – Available via department daily log
- **$ Purchases (broken down by vendor)** – Available via food service or accounts payable app or manual log
- **$ Floor stock supplied** – Available via patient services software
- **Perpetual Inventory** if available

The director should be afforded access and support for an electronic daily dashboard. Managing an FNS department is extremely complex and fast-paced. By maintaining a quick daily operational overview, the director and their designees will be more engaged, informed and better prepared to manage.

BUSINESS PARTNER SUPPORT

Strong Business Partners/Partnerships are a key component in building a successful self-op operation. These strategic partnerships come in many different forms including product purchasing programs either directly with a business partner, through a GPO or various other means.

Working with Business Partners allows an operator (Self Op) flexibility and choice when making key business decisions that can drive patient, staff and member satisfaction. Additionally, business partners provide direct access to innovation, new food trends and culinary support. They are the subject matter experts in their fields.

The benefit of working with your prime vendor distributor and GPO includes the ability to maximize supply chain efficiencies while uncovering opportunities for operational excellence using tools to maximize cost control and labor efficiencies. Examples of available tools and resources include, but are not limited to the following: GPO Maximization, contract compliance, business insights, data analytics, revenue enhancement, spend analysis, operational audits, calculating and comparing PPD to industry benchmarks, inventory software, staffing and labor analysis, etc.

Partnership with your suppliers and GPO's is an entry to doing business not just "nice to have."

View AHF's webinar on "Maximizing GPOs and the Supply Chain" **Business Partner Webinar**

SECURITY AND ENVIRONMENT

The department must have a policy that ensures the security of all food, supplies, cash, equipment and any sensitive information or data that is stored in computers or the POS System. We highly recommend the following:

- A policy delineating opening and closing procedures. Also drops and cash deposits.
- A safe cash counting room with limited access and digital monitoring.
- A policy on cash handling procedures that complies with generally accepted industry cash handling and accounting principles and PCI compliance. Including proper taxation on a state-by-state basis, and credit card downtime.
- A procedure for safeguarding keys and/or electronic passes.
- A current list of people authorized to access the department when it is closed which is provided to the hospital security department and others who have a need for the list.
- Train staff to deal with robbery, ID theft, and counterfeit bills.

CHAPTER 3
FINANCING THE PLAN: BUDGETING

DIRECT EXPENSE CATEGORIES

LABOR AND STAFFING

In the labor budget, predictions need to be made for the number of hours that will be worked by every position. Including but not limited to: Manager, Chef, Cook, Waiter, Dietitian, Hostess, Call Center Expediter, Cashier or Dishwasher. Those hours are then translated into **Full-Time Equivalents (FTE's)**. An FTE is normally 8 hours per day or forty hours per work week. To calculate the number of hours of Cooks time is needed for a week and divide by 40 hours. If the operation employs three 8-hour cooks in a day, 7 days per week, that is (3x8) x7/40 or 168/40= 4.2 FTE's weekly for cooks. This is done for every position and then extended or spread over the 52 weeks in a year, or sometimes for the number of pay periods in a year.

Also considered must be that there are salaried staff and hourly staff. This can be: Full-time Staff, Part-time Staff, and/or Per Diem Staff (relief staff with no guaranteed hours). Sometimes a business may also hire Temporary, Contracted, or Agency Staff. There may be Union and Non-union staff as well as exempt and non-exempt staff. **Exempt** means the position is salaried and does not incur overtime according to wage and hour laws. **Non-Exempt** staff is usually paid an overtime premium like Time and ½ for more than 8 hours per day or over 40 hours per week. Refer to a well labeled **Master Schedule** when doing a salary budget. The master schedule shows how many working shifts, and days off, that will need to be covered in one pay period or work cycle, usually two weeks.

In most of healthcare, employees earn PTO (Paid Time Off). This takes the form of sick days, vacation days, education day, medical or maternity leave, personal and mental health days. These days need to be accounted for in the budget. Most businesses create a budget using a **Relief Factor** depending on the staff turnover rate or how generous a benefit package is offered. The Relief Factor is a multiplier (usually by percentage) for each FTE of coverage. The relief factor can be as low as 1.08 for fast food positions or as high as 1.24 for healthcare nutrition departments. Since an FTE or 40-hour position works 2080 hours over a 52-week year. It would be appropriate to budget (2080 x 1.24) = 2579 hours to cover each FTE. Frugal businesses want to minimize staff working overtime or getting premium pay for exceeding 40 hours per pay period. Once the total number of hours and salary numbers have been calculated, that can be extended to calculate the Federal Insurance Contributions Act (FICA) that is needed to pay for Social Security.

FOOD AND SUPPLIES

- **Food** – Dairy, meat, baked products, staples and dry goods, frozen and vegetables, produce, beverages (concentrated versus cans and bottles).
- **Supplies** – Cleaning chemicals, cleaning tools, safety equipment, sanitation supplies (gloves/hairnets)
- **Small Equipment** (Smallware's) – China, insulated service ware, scoops, frying pans, knives, strainers, toasters, blenders.
- **Disposables** – Napkins, paper towels, foam cups and plates, plastic flatware, placemats.

OTHER EXPENSE CATEGORIES

- **Utilities and Facility Costs** – Annual preventive maintenance contracts, electric, gas, water, internet, phone, trash removal, recycling cardboard and fryer grease. Vehicle gas/maintenance. Snow removal. Landscaping.
- **Nutritional Supplements** – These may be ordered for patient by a physician or after screening by an RD. Because this expense is not always under the control of Nutrition Services, they are sometimes expensed to pharmacy.

REVENUE SOURCES

Revenue covers all the sales and transfers of goods and services and tracks the sources of the income. It is important to also watch when (time of day) the revenue comes in. Watching Revenues timing provides clues about what attracts customers to the business. A large hospital food service with multiple revenue centers might need to track any and all of the following sources of Retail Revenue:

- **Main Cafeteria** – Breakfast, Lunch and Supper (Day Parts)
- **Food Court** – Day Parts by Mexican, Pizza, Asian/Sushi, Grill, Deli & Subs, Wings & Fries, Vegan.
- **Coffee Kiosk** – Day parts, Beverages versus Grab and Go foods.
- **Coffee Shop with Bakery and Donuts** – Day Parts
- **Medical Office Coffee Service** – To offices and break rooms.
- **Convenience Store and Gift Shop** – Day Parts and food versus sundries.
- **Campus Hotel Restaurant** – Day Parts including Bar Revenue and Happy Hour appetizers.
- **Ghost Kitchen Delivery Service** – Campus delivery from multiple food outlets.
- **Meals on Wheels** – For seniors or Facility Daycare Centers.
- **Catering Service** – For meetings and events.
- **Vending and Autonomous Micro Markets** – Using self-checkout.
- **Transfers or "pass through" costs** – When other departments or cost centers under the same business umbrella acquires goods from food service that in not marked up for profit. For example: providing cases of coffee, water, soft drinks, or napkins to other departments, so supply chain or central purchasing does not have to purchase the items as well.

Obviously, this can get complicated. So large operations divide each distinct operation into **Revenue Centers.** A kitchen in a Hospital or Long Term Care Facility that does not produce revenue would be labeled a **Cost Center**.

RETAIL PRICING

Retail pricing and sales performance should be tracked by menu item and reviewed weekly. Recipes should be reviewed against cost and yield.

- Predicted food costs should be used to establish a price and reviewed as ingredient prices change.
- Actual food cost should be reviewed against predicted at least quarterly.
- Transactions and check averages should be monitored for trends.
- Menus should be evaluated regularly in response to ingredient availability.

CHAPTER 4
EVALUATING PLAN PERFORMANCE: REPORTING

COMMUNICATION MONTHLY WITH THE C-SUITE

Self Op Foodservice operators need to maintain frequent and consistent communication to administrators.

Goals for this communication are:

- Provide updates on department operations
- Celebrate achievements
- Concur on action plans and goals for the department
- Communicate that the department is well-managed

MONTHLY AND QUARTERLY REPORTS SHOULD INCLUDE:

Mission – Update on the vision and values and stories that illustrate these.

Leadership – What progress is being made on goals? What new initiatives are in place?

Financial Performance

- Tracking KPI's (Key Performance Indicators)
- YTD (year to date) financial performance versus budget
- Benchmark results on volumes, costs, and productivity
- Unexpected results or newly emerging issues
- Strategies to improve performance

Culinary and Service Satisfaction

- Audit results and survey scores
- Successes and accolades

Regulatory Compliance

- Cover food safety, staff safety, and sanitation.
- Asset Management including Capital Equipment and Staff Development

Clinical Services – Ways the clinical staff is affecting patient care.

TOOLS/TECHNIQUES FOR DATA GATHERING, TRACKING & REPORTING

MONTHLY AND QUARTERLY REPORTS

Use monthly reporting to keep administrator updates. Each operator should be familiar with what Senior Administration reports out to their Board, and how the Board interprets the data, and holds the respective C-suite member accountable for the data. Examples have been provided below.

DASHBOARD DAILY/ROUTINE TRACKING

It is crucial to stay on top of your numbers and have a routine for capturing issues in real time. A desktop dashboard is a great start. Whether you use a SharePoint site or an accessible Excel folder, you and your team should be looking at stats such as:

Daily:

- Adjusted Patient Days
- Patient Meals per Patient Day
- Non-productive Labor Hours
- Overtime
- Infections and contact precautions
- Incident Reports

Weekly:

- Test Tray Review
- Food Waste Review in the dish room

Monthly:

- Total Operating Expense per Adjusted Patient Day (net of cash)
- Patient Satisfaction Rate
- Meals per labor hour or per productive labor hour
- Floor Stock Cost per Patient Day
- Retail Sales by Revenue Center
- Supply Cost per Cost Center
- Paid Revenue as a % of Total Managed Volume
- Productive Hours per 100 Meals
- Staff turnover and Reason for Turnover

Quarterly:

- GPO Contract Utilization Rate

Yearly:

- Inventory Turns
- Colleagues per Leader
- Position Vacancy Rate ~ HR monitors more frequently
- Colleague Turn-over Rate ~ HR monitors more frequently

FIGURE 4.1 C-SUITE COMMUNICATION TOOL

Department	Department _____ Date _____	**Director**	Name _____

Financials			
Month _____	Actual	Budget	Previous Year _____
Revenue			
Volume			
RDN Visits MTN Transactions			
Expenses			
Manhours Productive FTE OT FTE Non-Productive FTE Total FTE			

Staffing	Month _____	Budget	Previous Year Month _____
Productive Manhours per statistic (meal)			

Goals for Next Year
Open Positions
Active FMLA's
Human Resources Issues
Sanitation Inspection Results
Interdisciplinary Updates
Updates from Department Meetings
Your Schedule – list all dates/times you will be out of the office:
Current Year Goals and Progress (list goals and progress made in the last month):
Highlights/Accomplishments
What can I do to help?

Courtesy of Hendricks.org

MONTHLY REPORTING TOOL – EX. 1

Develop this report on a monthly basis and provide a year end summary.

MEALS	ACTUALS	BUDGET	PRIOR YEAR	VARIANCE
Total Meal Equivalents/Registants				0
QUICK STATS				
Total Revenue				$ -
Total Operating Expense				$ -
Contribution Margin				$ -
FTE's				$ -
Total FTE's				0.00
FTE's				
Total Salaries and Wages				$ -
Total Employee Benefits				$ -
Total Medical Supplies				$ -
Total Other Supplies				$ -
Total Purchased Services				$ -
Total COVID-19 Supplies				$ -
Total Lease and Rental				$ -
Total Maintenance and Repairs				$ -
Utilities				$ -
Depreciation				$ -
Other Expenses				$ -
	ACTUALS	BUDGET	PRIOR YEAR	VARIANCE
Cost Per Patient Day				
Net Cost Per Meal Equivalent				
Net Cost Per Patient Day				
Total Patient Days				

Example monthly metrics to track:

METRICS	CURRENT MONTH	BUDGET/GOAL	VARIANCE
Total Patient Days			
Cost Per Patient Day			
Net Cost Per Meal Equivalent			
Net Cost Per Patient Day			

A fillable excel version of this dashboard can be downloaded on AHF's website under Self Operated Project Resources.

MONTHLY REPORTING TOOL – EX. 2

QUALITY & PATIENT SAFETY

Measure	Actual	Target	N	FYTD Actual	FYTD Target	Frequency
Monthly Safety Audit						Monthly
Retail Performance Audit						Monthly

PATIENT EXPERIENCE

Measure	Actual	Target	N	FYTD Actual	FYTD Target	Frequency
LGH- Real Time NRC Survey						Monthly
Patient Rounding						Daily
Room Service Process Audit						Weekly

FINANCE AND GROWTH

Measure	Actual	Target	N	FYTD Actual	FYTD Target	Frequency
Retail Sales						Monthly
Operating Expense						Monthly
Net Cost Per Patient Day						Monthly
Productivity						Monthly
Overtime						Monthly
Benchmarking Meal Equivalents						Annually

ENGAGEMENT

Measure	Actual	Target	N	FYTD Actual	FYTD Target	Frequency
GLINT eSat*						Semi-Annually
GLINT Participation						Semi-Annually
Employee Turnover						Monthly

KEY

- Goal Met
- Performance Approaching: <10%
- Goal Not Met
- Target Exceeded: >10%

**Employee Engagement (GLINT or other employee satisfaction or engagement survey tools may be utilized)*

A fillable excel version of this dashboard can be downloaded on AHF's website under Self Operated Project Resources.

NEVER TAKE THE BASICS FOR GRANTED.
Monitor, Measure and Make Sure – Every time

CHAPTER 5
ADJUSTING THE PLAN: ANALYZING PERFORMANCE

On a monthly basis, FNS leaders conduct thorough analysis of actual performance to baseline and to targets. Performance lags require immediate action. The process includes identifying the largest performance gaps and prioritizing them to focus attention.

OPERATIONAL EXCELLENCE: BACK TO BASICS

The first defense in financial management is operational excellence. Avoiding rework and waste produces results with predictable financial performance.

COMMUNICATION TECHNIQUES

No one knows the operation, its strengths and opportunities better than the front-line colleagues who perform the work and serve customers directly. They see the waste and complete the rework – and create work-around processes every day. Empowering them to problem solve and providing forums for obtaining their observations and feedback improves both operational and financial performance. High Reliability Organizations (HRO's) all engage this practice.

Line-Ups or Line Meetings (The Daily Huddle)

- Schedule 5-minute line-up prior to start of every meal.
- Include Manager, supervisor(s) and staff on duty involved in the production and service of food for all customer groups.
- Discuss the menu, demonstrate the proper plating/portion size, and identify any issues/ changes.
- Sample food – take corrective actions if needed and document the food quality and actions taken.
- Discuss the census, retail traffic expectations, and timing issues to keep meals on schedule.
- Hold huddles frequently through the week to include additional information needed by the team, but that would take more time than line-up meeting allows.
- Solicit issues – what has gone well and what needs work?
- Use time to discuss patient and other customer satisfaction and to recognize staff/ team successes.
- Always mention safety concerns.
- Incorporate brief, upbeat, training segments to reinforce key concepts, such as "flash card training" into each huddle.

Department Meetings

- Held monthly with all staff to cover broader topics and maintain normal communication.

Communication Boards

- Post current customer satisfaction scores by service unit.
- Spend time in huddle once per week on changes in satisfaction levels.
- Discuss opportunities and ask for staff suggestions.
- Post and recognize successful actions take

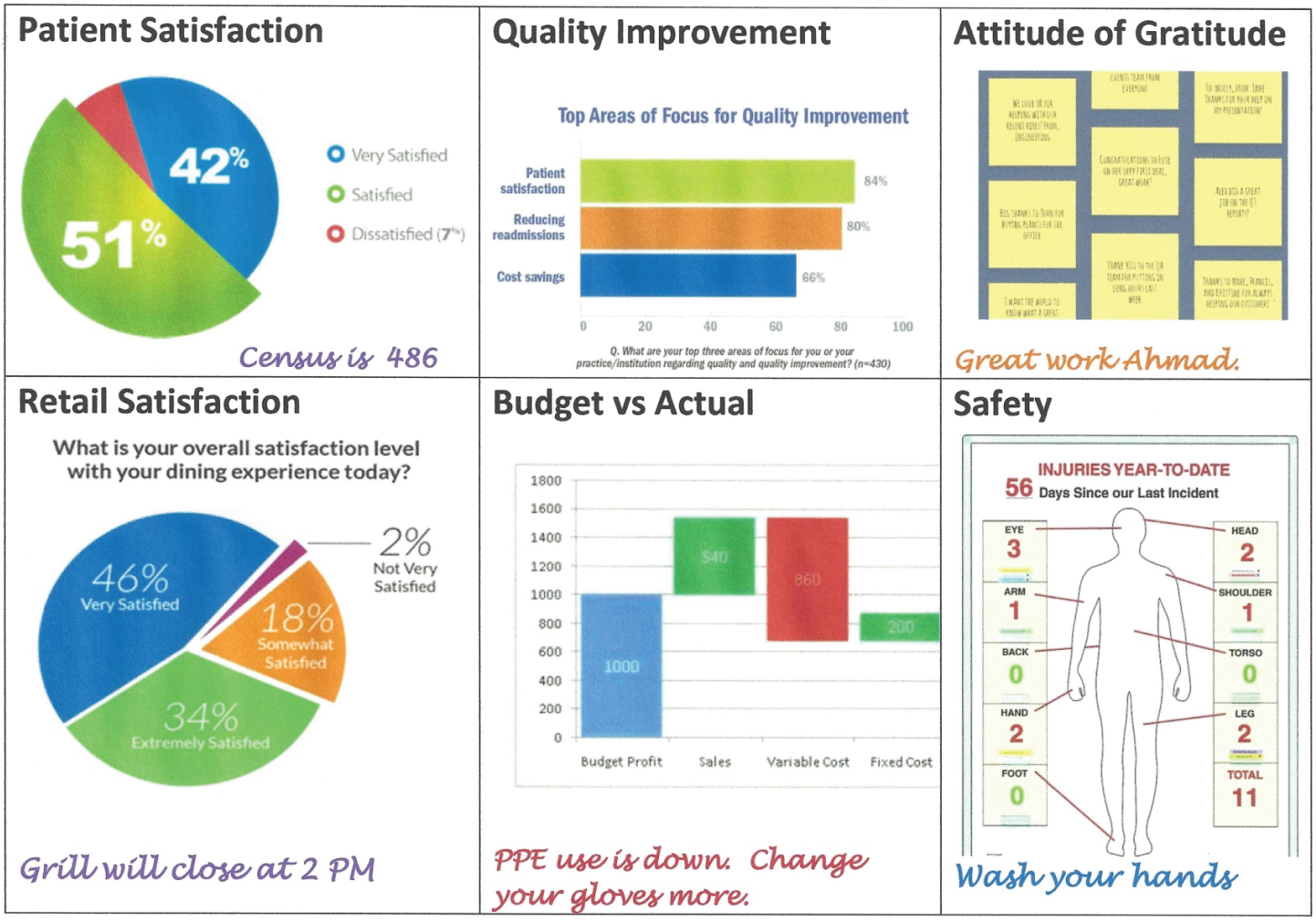
OPERATIONAL ASSESSMENTS

Conduct routine assessments and audits of the FNS operations to maintain survey readiness, identify best practices and identify opportunities for improvement.

SUPPLY CHAIN MANAGEMENT
The FIVE RIGHTS of Purchasing:

Right Product + Right Quantity + Right Price + Right Vendor + Right Time

FIGURE #2. SAMPLE HUDDLE BOARD WITH WHITE BOARD CAPABILITIES (UPDATED DAILY).



Food Formulary: Contract and Product Compliance
Create a standard food formulary for use, which reflects regional preferences, and builds upon the recommendations of the system's GPO. A formulary approach reduces cost for items purchased, enhances rebate generation, and identifies the need for additional/new contracts for essential product groups with no current purchasing agreements available.

Regional/Local Contracts
Identify opportunities where needs exist that cannot be met via existing purchasing agreements. From small contracts for local or regional fresh donuts to grocery store agreements for the last-minute store runs that are frequently essential, to pizzeria pizza, and sole source pouring rights, there are many unmet needs.

Purchasing Standards
Use technology and hard-wire the food formulary, as well as standard vendors. Purchase products from vendors with contracts to obtain best pricing and support quality consistency. Track spending monthly to determine contract utilization rates, non-contracted vendor spend, and rebate generation. Utilize reports from the GPO, prime vendor, and your organization's A/P service to monitor performance.

Product Selection and Review
Conduct product cuttings and sampling of contracted products to refine the formulary on a routine basis and to identify appropriate replacements for non-compliant products. Engage department colleagues and multiple stakeholders in selection to assure consensus and acceptance. Ensure system or departmental nutritional standards are maintained acceptance.

Separation of Duties and Audit Process
General accounting practices require that the order, receiving and invoice approval process be separated to safeguard the integrity of the process. Depending upon the size of the operation, the executive chef or production manager places orders with vendors. A storeroom coordinator cook or other trained department colleague receives the deliveries and documents the accuracy of receiving documents. The department director or an assigned business manager approves invoices for payment.

When using technology for purchasing, the software produces the purchase orders and, upon appropriate manager approval, places the orders electronically. Procedures for documenting receipt and approving invoices for electronic payment within the software document the separation of duties and expedite payments to vendors. This type of technology application facilitates auditing and reduces expense by maximizing contract compliance and capitalizing on prompt pay discounts.

FOOD PRODUCTION

Forecast needs for meal production utilizing food management software that helps track actual usage and uses history to refine production requirements, thus reducing waste and food cost. Complete and refine the forecast weekly for patient, retail, and catering menus to control food cost, avoid over-production, and reduce pre-consumer waste. Calculate purchase requirements based upon updated forecasts. Use the same forecast to calculate production reports and extend recipes. Each day, record the actual quantities ordered by patients, sold in the cafeteria(s), served in the physician dining room(s), sold in other retail outlets, and delivered for catering events. Use the actual volumes to update the forecast for the menu's next service. After updating usage reports, use the software to calculate the cost of overproduction and evaluate waste levels. Refine the forecast to reduce the waste level as an ongoing lean practice.

- Forecasting and accurate production reports assure purchase and production of appropriate quantities.
- Accurate standardized recipes, consistently followed, contain correct ingredients, and match the menu.
- Established Food Quality Standards (FQS) are enforced, assuring food items are tasted, evaluated, and appropriate corrective action is taken before meal service.

Utilization Control
Analyze and control the utilization of product to reduce costs. Generate savings by appropriate utilization of product. Forecast and track patient, retail and complimentary meals, amenities, and services. Compare actual service rates to expectations to identify potential over-utilization and wasted resources. Track the cost per patient day of floor stock, pantry supplies, patient amenities. Control access to food supplies in all areas to establish appropriate utilization levels.

Floor Stock
A formulary and process for floor stock and patient amenities assists in managing the cost and controls the usage on a per patient day basis. Track floor stock, defined as standard items typically issued to patient care areas that have a clinical or practical application for patients, and amenities, defined as items for which there is no clinical basis and are not typical issue, such as cookies. Calculate the cost of floor stock and amenities per patient day to define utilization rates. Control access of products. Typically, issue amenities only to specialty, high-amenity units, where they contribute to the service definition.

Create electronic floor-stock requisition templates (apps) for patient care areas. Use requisitions to issue track costs for each unit. Report and compare cost per patient day by unit to identify opportunities to control expense.

INVENTORY MANAGEMENT, EXTENSION AND CONTROL

Most effective ways to manage inventory involves using technology. If the department does not own adequate software for this purpose, most broad line foodservice distributors support routine inventory value reporting features. Each month, update prices from the prime vendor (typically done electronically). Update prices from other

vendors, at least once per quarter. On a consistent date each month, print inventory worksheets and conduct physical inventory. Use the electronic system available to value the inventory and compare to prior periods. When inventory values increase, additional resources are sitting on the shelf. As a business practice, maintain inventory value as consistently as practical. Avoid artificial variations by conducting physical inventory on the same day of the week (versus using the same DATE of the month) and the same week each month, avoiding the day of or immediately following large delivery days. Note: Excessive inventory levels may represent an opportunity to utilize items carried in inventory for extended periods due to menu changes or previous events.

SUSTAINABILITY INITIATIVES

Implement sustainable green approaches to FNS operation where overall cost savings will be achieved. Just a few opportunities to explore include reduction of disposable use, green mug programs for beverage service (if post-COVID-19 conditions allow) reduction of disposable take-out service, expansion of recycling, composting and food recovery (donation) initiatives.

MENU ENGINEERING

All foodservice operations begin and end with the menu. Improve menu planning by eliminating slow-moving products, redesigning items that fail to achieve margin targets and maximizing the impact of popular, high-margin products. Utilizing a common platform for management software, diet office applications and point of sale allows cost identification prior to menu service and actual usage figures provide needed data for menu engineering. This can be difficult with printed patient menus but is easily incorporated in room service (chef specials) and retail operations.

To assure financial performance, incorporate the following:

- Use apps to plan the menu to monitor menu metrics and achieve goals.
- Calculate food cost during the menu planning process and monitor actual costs.
- Define portion sizes and plating instructions.
- Limit cycle length and selection to maximize inventory turns and assure production consistency.
- Base patient-menu content on patient popularity index, age, culture, regional preferences, and language needs, assuring nutrient content meets regulatory requirements.
- Thoroughly test for all diets and combinations for accuracy.
- Provide attractive, easily read printed menu to set a positive expectation for patients.
- Maintain trays and all service components in good repair and replaced when needed, on a planned basis.
- Establish, monitor, and assure compliance with tray/meal standards.
- Print tickets for every tray served to assure accuracy in diet/allergies and meal counts.
- Monitor timeframe from build to delivery to protect food temperatures, meal quality and patient expectations.
- Assure food is at the correct temperature to promote safety and avoid need to replace meals.
- Basic cafeteria menus include steam table and “grab ‘n’ go” services. Typical additions include grill, deli, salad bar and rotating display stations.
- Bundled value meals can increase check average and encourage participation.
- Providing daily healthy plate meal deals with full nutrition labeling assists employees in making healthy choices.
- Printed and electronic signage and intranet marketing promote sales.
- Use of point-of-sale reports assists in analyzing the popularity index. Comparing product margin to popularity assists in developing a menu matrix.
- Change menu seasonally.
- Post menu, prices, and specials professionally.

RETAIL MANAGEMENT

Implement consistent processes for retail operations, including enhanced marketing and consistent cash control procedures. You can download AHF’s Retail Checklist to get started here.

REVENUE RATIOS AND MARGIN MANAGEMENT

Whether or not you are a Profit and Loss Department (P&L), you need to know your margins.

- Profit Margin = Net Profit / Sales
- Food Cost % = Cost of Food / Sales
- Labor Cost % = Labor Cost / Sales
- Cost of Goods Sold (COGS) = (Purchases + Beginning Inventory) – Ending Inventory
- Portion Cost = (Food + Direct Labor Cost) to make recipe / # of portions produced
- Selling Price = Portion Cost ($0.85)/ desired Food cost % (0.25) = $3.40

CORE GUIDELINES FOR RETAIL SERVICE

Maximize the financial performance of retail operations by treating them as a business unit. Download the AHF Retail Checklist here.

Environment

Keep the dining spaces clean, organized, and convenient for customers. Conduct routine environmental audit of cafeteria service and dining areas. Key factors:

- Remove clutter from all site lines. Keep cardboard and other packaging out of the café.
- Assure tables and chairs are orderly, clean and in good repair.
- Assure that walls and floors are clean and in good repair.

Quality and Value

- Keep food fresh, attractive, and safe throughout all meal hours.
- Conduct routine customer surveys to measure satisfaction and adjust program accordingly.
- Implement signage and other techniques to assist diners in making healthy choices.

PRICING STRATEGIES

Implement carefully researched consistent pricing policies to maximize retail margins and increase revenue generation in the retail operations.

CASH CONTROL AND AUDIT PROCESSES

In collaboration with financial services, define standard process for cash control. Key points in the standard includes:

- Secure change banks in dual locking safe. Count and verify change banks on each shift.
- Require two parties to be present when counting cash.
- Once counted and issued to a cashier, the cash drawer remains in the sole control of the cashier until reconciled at the end of the shift. Do not allow sharing of cash drawers during a shift.
- Deliver cash deposits to the hospital cashier at the end of each shift with appropriate information for recording the deposit in the General Ledger (GL). Obtain cash for change banks via secure process.
- Consider automation for cash counting and cash register drawer set up. It saves labor and reduces counting errors.
- Conduct periodic cash audits by accounting department to confirm amount of all change banks and to verify cash control processes are consistent with policy and consistently followed.
- Utilize electronic forms for use in cash reconciliation process. (see attached).

CASHLESS PAYMENT OPTIONS

Providing cashless options for visitors and employees increases sales through increased number of transactions and check average per transaction.

- Credit/Debit Card processing must work through the point-of-sale system and meet current industry regulatory requirements for customer control and data encryption.
- Payroll Deduction systems require coordination with human resources and payroll processing. To be accurate and secure requires that the sale be processed through the point-of-sale system and the transaction details flow electronically to the payroll record.

COMPLIMENTARY SERVICE CONTROL

FREE MEALS

Implement a consistent process for the administration and provision of free meals. Although every hospital provides free meals to some groups, there are vast differences between how many meals are provided, who receives free meals, the value of the

meals provided and how they are accounted for in the financial reports. Some free meals are charged to other departments, some remain in foodservice. This variation makes comparisons difficult and the lack of consistency represents a great opportunity for cost savings. Check averages for free meals tend to be higher than, often twice as high as, paid meals. Tight control processes reduce the overall expense of providing free meals to those who meet the standard criteria and eliminate the cost of those who do not.

Key Components to Recommended Standard

- All free meals served in the cafeteria(s) must be accounted for in the POS. Process all complimentary meals through POS, recording the full value of the meal, and charging the meal to a designated account.
- If recipients pay a portion of the meal value, the full value is recorded in the POS, the amount paid is tendered as cash (or other payment as received) and the remaining amount is charged to the complimentary meal account.
- Groups approved for ongoing complimentary meals are set-up with individual accounts, provided a unique account number via bar code or written number, attached to the identification badge. The account is pre-loaded with the individual's meal budget and account number. When an individual with a "free meal account" exceeds the approved amount for the account, offer the opportunity to use a secondary tender for the excess amount.
- Provide a monthly detailed report to the leader accountable for the complimentary group of complimentary services by user to assist in identifying any abuse of policy and opportunities to reduce overall complimentary service costs.
- Track and report all complimentary charges on monthly department activity reports.

MARKETING & MERCHANDISING

RETAIL PARTNERS

Develop contracts for retail partnerships that are mutually advantageous. Some hospitals have retail food court partners providing anything from coffee kiosks to delivered resale items (Pizza to Chicken) to submarine sandwiches. Such contracts define the hours, services, menus, pricing, rental agreements, and profit sharing.

VENDING SERVICES & MICRO MARKETS

Vending may be provided in-house or sub-contracted to an outsourced provider. Whether direct revenue or commissions from the vendor, vending represents an opportunity for increased revenue and improved margins. When managed by the department, adequate controls should be in place to ensure maximum profits or commissions. Controls should be in accordance with department policies and procedures if self-operated. Or they should match the vending contract specifications.

CATERING SERVICE PROGRAM

Cash catering provides an opportunity to increase revenue and enhance department margins. Complimentary catering services represent an opportunity to tighten guidelines and approval criteria to generate additional savings. If catering is outsourced to off-site providers at retail pricing, there may be an opportunity for savings to the hospital by providing the service onsite with existing FNS Staff.

CATERING MENU

Providing a standard menu for catering services allows for predictable catering costs. Creating menus for major events using FNS software systems can control the event costs.

KEY COMPONENTS TO RECOMMENDED CATERING SERVICE STANDARDS

- All catering must be provided in-house by FNS department unless exception approved by CEO.
- All catering events must be approved by hospital CEO, COO, or CFO.
- Routine and standing events must be pre-approved and budgeted for the year.
- Special events must come from the CEO discretionary budget for catering approved/ budgeted for the year.
- Complimentary catered events must meet one of the following criteria:

- Standing committee of the BOD (Board of Directors or Trustees) or Medical Staff
- Annual or Quarterly events, such as Medical Staff Quarterly Meetings, Doctor's Day, Hospital Week
- Special event celebrating hospital-wide function, such as Frist Award celebration
- Marketing Event designed to grow business

- Meetings with all-employee attendees or with a minority attendance of physicians do not qualify for catering.
- Catering request forms are submitted electronically to a designated Mailbox established for CATERING.

MEDICAL STAFF SERVICES

PHYSICIAN DINING ROOMS – MEDICAL STAFF LOUNGE

Providing a comfortable, inviting lounge and appropriate meals and refreshments for medical staff is a standard business decision. Maintain high standards in a contract compliant fashion while monitoring and controlling the costs.

MENU

Develop the menu for Medical Staff using the same software as other service areas. Forecast and manage production as for any other service area.

CLINICAL NUTRITION SERVICES

INPATIENT AND OUTPATIENT NUTRITION SERVICES

When evaluating the food and nutrition department an important area to review is inpatient and outpatient nutrition services. Inpatient and outpatient nutrition services have a vital role to play in improving the health and wellbeing of the community. To achieve best financial management practices, it is important to conduct a thorough review of all services offered in both areas.

Registered dietitian nutritionists (RDN)'s are present in inpatient clinical settings and many outpatient settings including dialysis, cardiology, oncology, orthopedics, sports and wellness departments.

Consider current outpatient programs and those that could potentially be added to the service list. Many may be billable services and those related reimbursement levels for offered services. These services offer opportunities to provide revenue streams that help offset the overhead costs of inpatient and outpatient nutrition services. It is also important to review services that are not currently being billed but could generate revenues if a billing structure were instituted.

AHF offers a more detailed review of inpatient and outpatient nutrition services in the Clinical Nutrition Management section of self-op tools. It is a very complete guide and was just developed in 2020. Download AHF's Clinical Nutritional Management Publication here.

ESTABLISH RELATIONSHIPS WITH HEALTH INFORMATION MANAGEMENT (HIM), CODERS, AND PROVIDERS

To achieve financial success in both inpatient and outpatient nutrition services, the department need to establish excellent relationships with the HIM department and their medical coders and providers. When RDN's in the inpatient area work closely with these medical professionals, proper identification and coding of malnutrition, morbid obesity and underweight may result in increased reimbursement. It is key to report this data on a monthly basis to support the work of the RDN's, providers, interdisciplinary team, documentation specialists and coding. The increased reimbursement is achievable on both the inpatient and outpatient venues.

CLINICAL IMPACT ON FINANCIAL PERFORMANCE

The work of RDN's can impact the financial performance of the department. Outpatient diabetes medical nutrition therapy, other outpatient nutritional therapies, and weight management classes contribute to financial success. Pairing RDN's with a recognized diabetes education program can yield even larger benefits for your clients and the department. Currently a recognized diabetes education program is reimbursed at a higher rate for medical nutrition therapy than a non-recognized diabetes education program.

RDN's play a major role in assisting providers

with the correct assessments of body mass index, underweight, obesity and morbid obesity. Enhanced payment opportunities exist when the proper identification and assessments are noted in the medical record.

The hierarchy of coding is an important consideration and one that deserves time and attention. By developing a close working relationship with the HIM department, systems should be developed that allow for data capture and reporting. It is important to capture all billable charges, monitor and receive reports on billable charges, denials, reasons for denials, and actual reimbursement levels for clinical nutrition services. Obtaining this level of detail can be challenging in the hospital setting as clinical nutrition services may be perceived to be a minor financial contributor. While reimbursement for nutrition services needs improvement, studies validates these low-cost nutrition consultations and services save major dollars on readmissions, reduced medication usage, and improved quality of life.

MALNUTRITION IDENTIFICATION

Nutrition focused physical exams (NFPE) conducted by RDN's serve as a necessary assessment tool to properly assess and identify malnutrition and specific nutrient deficiencies. The Academy of Nutrition and Dietetics (AND) and American Society of Parental and Enteral Nutrition (ASPEN) provide ongoing updates, clinical standards, and practice standards. These evidence-based tools and resources should be available to the clinical dietitians. Academy members should visit the Academy website and review the malnutrition section on the Academy's member only website.

A close working relationship between RDN's, providers, and coders: will improve the screening, assessment, intervention, care plan, coding, and reimbursement reporting.

CLINICAL PRODUCTIVITY STANDARDS

A national standard model for determining the number of RDN's necessary to staff the inpatient acute care facilities does not yet exist. The Academy of Nutrition and Dietetics (AND) has assisted with two large RDN productivity studies. While these studies are not complete and do not provide an absolute staffing ratio matrix, the studies do provide guidance for clinical nutrition managers and directors. Members of AND have access to these studies.

TELEHEALTH – MEDICAL NUTRITION THERAPY

Telehealth in the United States is gaining in popularity. Medical nutrition therapy is a covered benefit under Medicare when provided via telehealth under certain conditions. The use of telehealth is an excellent opportunity for food and nutrition departments to expand and reach more clients. Directors and clinical managers will need to be well versed in current Medicare rules and have the support of the HIM coders to support telehealth delivery.

Providers must be able to deliver the services with a secure, HIPPA compliant delivery method. Documentation in the electronic medical record must also meet current standards.

https://www.eatrightpro.org/practice/practice-resources/telehealth/practicing-telehealth

Contract management companies often benchmark through an internal system that sets targets that are more aggressive than a traditional GPO system, and may change those numbers to to suit the specific contract they are trying to retain or bid.

CHAPTER 6
BENCHMARKING – COMPARING EFFECTIVENESS OF PERFORMANCE

In any healthcare food service, the first order of financial control is the budget. A Directors ability to justify budget variances is critical to keeping upper management and the finance department informed, and confident in department management. The budget and past performance lets everyone know how things are going internally. But how can you convey that a self-operated foodservice is providing good value for the money that was allocated to the department. *Answer: Benchmarking.*

Benchmarking is a process through which performance is measured by comparing foodservice operations against each other based on identical mutually agreed upon criteria (metrics). Regulatory agencies set minimums for staffing and standards for meal provision in acute and long-term care facilities. But after those minimums, all Food and Nutrition Service (FNS) Businesses diverge. They are then affected by healthcare demographics. The Hospitals size (bed count), patient and outpatient volumes, climate, population density of the market location, attachment to academic training, and whether it is a for-profit or not-for-profit business. These differences add requirements, but also economies of scale to the business. Subsequently, benchmarking is best between businesses that are comparable in size, volumes and location or setting (urban or rural).

Sometimes benchmarking between the facilities is difficult due to inconsistencies in financial reporting practices. One of the goals of this Financial Best Practices publication is to assure that Key Performance Indicators are calculated in a uniform manner. Establishing and following a consistent methodology for GL sub-account assignment is essential. That then becomes a Key Strategy for effective benchmarking.

Examples of tools that have been developed are located in the AHF's website here. To be effective requires improved consistency in the assignment of costs to general ledger accounts, use of cost center numbers for sections of FNS, consistent distribution of vendor rebates, and consistency in inter-departmental transfers practices. Data-gathering via FNS Software and standard tools results in data that cannot be manipulated or self-reported, generating accurate comparisons.

KPI'S FOR SUCCESSFUL BENCHMARKING INCLUDE:

- The cost to produce patient/non-patient meal/meal equivalents
- The hard and soft revenue offsets that influence the Foodservice Department's net cost
- The productivity for the Department based on either meals per productive labor hour or productive hours per meal.

OTHER KPI'S TO INCLUDE:

- Average Retail Transaction
- Total Dietitian Hours Worked per Patient/Resident Day
- Floor Stock per Patient/Resident Day
- Total Food Cost per Patient/Resident Day
- Labor Hours per Meal
- Net Cost per Patient/Resident Day
- Net of Cash per Patient/Resident Day
- Contribution Margin
- Total Patient/Resident Days
- Supply/Other Cost per Patient/Resident Day
- Total Meals
- Total Patient/Resident Meals

USING THE DATA

It is not always easy to find a group of similar Healthcare operations for comparison. The AHF Benchmarking database is the largest of its kind. It also provides a month-to-month and year-to-year representation of how your operation may be compared to others in self-operated healthcare foodservices. It helps you to answer the following questions:

- Where are your weaknesses
- Which areas you can improve
- New or different ways to do things Strategies for improvement
- Where are your strengths and how to maintain them
- Where you can increase efficiency
- Forecasting for the future
- When you are new to the facility and trying to understand the operation
- Orienting new leadership to your department and services
- Justifying staffing levels
- Identifying the impact of operational changes
- Administrator oversight and cost control discussions
- Budget planning and preparation
- Proposing changes in service
- When you are new to the facility and trying to understand the Operation
- The data base includes Acute and Long-Term Care Facilities.

Not only does this information make the operation better and each manager better, but it also takes the anxiety out of answering financial and performance questions. It also provides the numbers needed for planning, re-investment, and ROI calculations. The AHF Self-Op Team and the Benchmarking Committees have operators that can offer guidance regarding operational efficiencies and professional consulting may also be available through our CPAP Program.

CHAPTER 7
GLOSSARY

ASSET – An item of tangible value that a business entity owns (purchased or acquired) that can be sold or used to generate income. This includes equipment, inventory, real estate, bank accounts, patents, trademarks or contracts for future business, or outstanding debts that can be valued in cash.

ADJUSTED PATIENT DAYS – Adjusted patient days an aggregate figure reflecting the number of days of inpatient care, plus an estimate of the volume of outpatient services, expressed in units equivalent to an inpatient day in terms of level of effort. The figure is derived by first multiplying the number of outpatient visits by the ratio of outpatient revenue per outpatient visit to inpatient revenue per inpatient day. The product (which represents the number of patient days attributable to outpatient services) is then added to the number of inpatient days. Originally, the purpose of this calculation was to summarize overall productivity and calculate a unit cost that would include both inpatient and outpatient activities. Typically adjusted patient days may reflect a 25-30% increase over patient days.

Formula: Patient Days X (Gross Patient Revenue/ Inpatient Revenue) = APD Reference: The American Hospital Association

BENCHMARKING – Activity of comparing one's numbers with past performance (internal) or with predetermined statistical data from other comparable operations (external) and comparing performance on Key Performance Indicators (KPI).

BUDGET – A strategic financial plan for resource utilization (usually in dollars) for a specific period of time (normally one year). A budget puts limits on how much can be spent (expenses) versus what is collected in revenue or reimbursements. Budgets can be monitored on a weekly or monthly basis to determine whether the rate of incurring cost and expenses, and the collection of revenue is within the limits set in the annual operating budget.

Operating Budget: An operating budget is broken into line items that reflect each class of expense or cost as well as each class of income or revenue. This budget includes Cash Flow considerations.

Capital Budget: A plan to improve or replace major pieces of equipment or business infrastructure or property. This can also include new building, or the expansion or refurbishing of existing structures.

BUDGET VARIANCE – The difference between actual and budgeted dollar amounts

BUSINESS PLAN – A formal document that analyzes the costs, projected revenues, marketing plan, time frames logistics, activities and projected profit

CATERING CASH – Total cash, debit card, credit card less sales tax received for catering in the month. Do NOT include catering transfers to other areas. Catering markup should be 2.75 times food cost for Benchmarking.

CLINICAL LABOR COSTS – Inpatient and Outpatient - Total cost of WORKED hours per month excluding benefit pay such as vacation, ill time, holiday pay, employer contributions to Social Security or Medicare, worker's compensation insurance, state and federal unemployment taxes, state disability sick pay, health insurance, employee discounts for clinical dietitians and clinical diet technicians for inpatient and outpatient areas.

CONTRIBUTION MARGIN – Retail Cost minus total Retail Cash and non-cash sales combined.

COST/BENEFIT ANALYSIS – Analysis of the costs and benefits of a capital expense or other program including the costs of not making the purchase and the projected payback period. Formula: Total cost / total revenue (or benefits) = length of time (payback period).

CREDITS (TRANSFERS) – All costs transferred from foodservice budget to other cost centers

including: Catering, Free Meals, Physician Meals, Employee Discounts, Guest Trays, Nourishments and Tube Feedings.

FLOOR STOCK – Bulk supplies of food and beverage supplied for the patient care areas for patient use

FOOD COST (TOTAL) – Sum of the cost for food excluding nourishments, supplements, tube feedings and floor stock. Calculated using paid vendor invoices.

Food Cost Per Resident/Patient Day: Patient Food Cost ÷ Adjusted Patient Days per Month

FOREGONE REVENUE – Foregone revenue includes all items that you should get credit for in your operation but do not because of Administrative/ Financial policies. These items represent real costs to the Department for which you are either not compensated or receive partial compensation. The reason to report Foregone Revenue is to calculate meal equivalents for these costs. For formulas, got to Benchmarking Express Glossary.

FTE – Full time equivalent - number of hours per week that a full time staff member will work on an annualized basis (if a full time person works 40 hours works per week, then an FTE = 2080 hours/ year)

KEY PERFORMANCE INDICATORS (Also referred to as KPI or Metrics) – Ratios, percentages or other mathematical formulas using the collected department data (numbers that give the operator insight into one's operations.

LABOR COSTS – Total cost of WORKED hours per month excluding benefit pay such as vacation, ill time, holiday pay, employer contributions to Social Security or Medicare, worker's compensation insurance, state and federal unemployment taxes, state disability sick pay, health insurance, employee discounts. Goal is to capture the salary cost for those in productive pay hours (worked hours) as opposed to paid hours. Excludes clinical dietitians and clinical diet technicians.

LABOR HOURS

Productive Hours: Regular, overtime, agency hours and premiums paid to staff.

Nonproductive Hours: Sick, vacation (PTO), or continuing education time paid to staff.

MEAL/MEALS – Is a standard measurement to access volume of activity, productivity, or output of a food service department. In the Health Care environment, meals are usually divided into Patient Meals (food served to patients/residents) and Non-Patient Meals (food served in the cafeteria and other food retail outlets including catering and free meals).

MEAL EQUIVALENTS – In calculating patient and non-patient meals in calculating Patient and Non-Patient Meals, a Meal Equivalent is used to convert patient food items (such as floor stock and nourishment's) and non-patient sales (such as cafeteria and catering sales) into a Meals figure. Or do the following:

- Count patient trays.
- Determine the cost of floor stock, nourishments/supplements, and supplements and divide this figure by the Average Cafeteria Transaction, (this will yield a Patient Meal Equivalent figure) If you do not have a cafeteria, use $3.30 (2019 Figure).
- The sum of the patient trays, plus the result of the costs of floor stock/nourishments etc. divided by the Average Cafeteria Transaction, yields **Total Patient Meals**. (this figure is sometimes referred to as the total of patient meals and patient meal equivalents)

MNT – Medical Nutrition Therapy

METRICS – See Key Performance Indicators.

NET OF CASH PER PATIENT DAY – (All Costs) - (Retail Cash + Catering Cash + Other Cash)) ÷ Patient/Resident Days

GLOSSARY

NET COST PER PATIENT DAY – All direct costs ÷ total patient days

NON CASH RETAIL SALES – Total dollar amount of free meals sold in the café (volunteer meals, physician's meals). Do not include sales tax or discounts.

NOURISHMENT/SNACK – A prescribed or requested snack that is provided between meals

OTHER CASH – Cash received that is not included in other categories. Including: Vending, Rebates, Outpatient clinical Dietitian Services, Meals for other facilities, Commissions from leases and rents, Guest and patient meals not otherwise reported.

PATIENT DAYS – "The cumulative census at midnight (excluding newborns), plus the number of patients who were admitted and discharged on the same day and never included in the census. This includes NPO's". *Reference: The American Hospital Association*

PERPETUAL INVENTORY – A "running or real time" record of the balance on hand for each item of goods in the storeroom.

PRODUCTIVE LABOR HOURS – Actual number of worked hours for the month for foodservice department staff. Exclude worked hours for clinical dietitians and clinical dietetic technicians.

RETAIL CASH – Total cash, debit card and credit card payments less sales tax received for the month in retail food operations that are self-operated. Do not include anything that you bill to other departments.

TOTAL COST OF SUPPLIES – Any cost that is neither food nor labor. Examples include: disposables, china, uniforms, utensils, small ware, minor equipment (under $1,000), computer supplies, linen rentals, equipment rental, chemicals, cleaning, linens, forms, menus, knife sharpening and office supplies.

TOTAL NOURISHMENT, SUPPLEMENTS, TUBE FEEDINGS AND FLOOR STOCK COST – Sum of the cost for nourishments (in- between meal feedings, diabetic snacks and between meal snack carts services), supplements, tube feedings and floor stock. Calculated using paid vendor invoices, without markups.

TOTAL OTHER DIRECT COSTS – Not consumed as part of creating meals. Some examples include travel, professional development, membership dues, maintenance fees, consulting, and engineering. Do NOT include space rental, capitalized leases, or equipment depreciation.

TOTAL PATIENT TRAYS – Two methods. Choose one and use consistently.

- **Physical Tray Count**
  - Count patient trays for inpatients and outpatients.
  - Includes outpatient meals, Emergency department and after-hours meals.
- **Calculated Estimate**
  - Patient days (excluding newborns) times 3.0.
  - Tray count for other meals including outpatient areas and emergency department.
  - **Note:** Guest trays and parent trays are NOT included in patient meals. If they can be separated, they should be recorded in transfers and credits or Foregone Revenue.

TOTAL RETAIL TRANSACTIONS – The total number of transactions recorded in cafeterias including cash, debit card, credit card and noncash sales.one totaled cash register sale, or a set dollar figure divided into the total sales.

TOTAL PATIENT/RESIDENT DAYS – Facility patient days excluding newborn days. This is usually available from finance departments and is NOT adjusted patient days.

VALUE – When an organization is provided goods and service at a better than competitive price using the least amount of its limited resources.

AHF members and staff are continuously on the fore-front of operations during unique events and in normal operational times. We are committed to revisiting the suggestions and predictions in the near future to see how our industry has adapted. We would welcome any new ideas or thoughts as we move into the 'next' normal of operations.

ASSOCIATION FOR HEALTHCARE FOODSERVICE

AHF is the premier national association representing the self-operated foodservice industry in healthcare, senior dining, and related industries.

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